Agency 129
Kansas Health Policy Authority

Editor's Note:
K.S.A. 2005 Supp. 75-7401 thru 75-7405 and Section 42 of Chapter 187, 2005 Session Laws of Kansas transferred specific powers, duties, and regulatory authority of the Division of Health Policy and Finance (DHPF) within the Department of Administration to the Kansas Health Policy Authority (KHPA), effective July 1, 2006. The statutes provide that KHPA will be the single state agency for Medicaid, Medikan and Health Wave in Kansas.

Editor's Note:
The Division of Health Policy and Finance was established by 2005 Senate Bill 272. K.S.A. 2005 Supp. 75-7413 transferred specific powers, duties, and regulatory authority of the Secretary of Social and Rehabilitation Services on an interim basis to a new Division of Health Policy and Finance (DHPF) within the Department of Administration, created under K.S.A. 2005 Supp. 75-7406, effective July 1, 2005. The statute provides that DHPF will be the single state agency for Medicaid, Medikan and HealthWave in Kansas. The statute also establishes the Kansas Health Policy Authority (HPA) which will eventually assume these programs as well as other medical programs for the State of Kansas.

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Article 5.—PROVIDER PARTICIPATION, SCOPE OF SERVICES, AND REIMBURSEMENTS FOR THE MEDICAID (MEDICAL ASSISTANCE) PROGRAM

129-5-1. Prior authorization. (a) Any medical service may be placed by the Kansas health policy authority on the published list of services requiring prior authorization or precertification for any of the following reasons:

(1) To ensure that provision of the service is medically necessary;

(2) to ensure that services that could be subject to overuse are monitored for appropriateness in each case; and

(3) to ensure that services are delivered in a cost-effective manner.

(b) Administration of covered pharmaceuticals in the following classes shall require prior authorization. A cross-reference of generic and brand names shall be made available upon request:

(1) Ace inhibitors:
(A) Quinapril;
(B) moexipril;
(C) perindopril;
(D) ramipril; and
(E) trandolopril;
(2) acne and skin lesion products:
(A) Tretinoin; and
(B) alitretinoin;
(3) adjunct antiepileptic drugs:
(A) Gabitril; and
(B) zonegran;
(4) angiotensin II receptor antagonists:
(A) Candesartan:
(B) candesartan-HCTZ;
(C) eprosartan;
(D) eprosartan-HCTZ;
(E) olmesartan; and
(F) olmesartan-HCTZ;
(5) antibiotics: telithromycin;
(6) anticholinergic urinary incontinence drugs:
(A) Flavoxate;
(B) oxybutynin XL;

(C) tolterodine;
(D) oxybutynin patches; and
(E) trospium chloride;
(7) antiemetics: nabilone;
(8) antipsoriatics: alefacept;
(9) antiretroviral drugs:
(A) Enfuvirtide; and
(B) Selzentry®;
(10) antirheumatics:
(A) Leflunomide;
(B) infliximab;
(C) anakinra;
(D) adalimumab;
(E) etonercept; and
(F) abatacept;
(11) cervical dystonias: botulinum toxins A and B;
(12) drugs for the treatment of osteoporosis: teriparatide;
(13) antituberculosis products:
(A) Aminosalicylate sodium;
(B) capreomycin;
(C) ethambutol;
(D) ethionamide;
(E) isoniazid;
(F) pyrazinamide; and
(G) rifampin and rifampin-isoniazid combinations;
(14) all decubitus and wound care products;
(15) all intravenous and oral dietary and nutritional products, including the following:
(A) Amino acids, injectable;
(B) 1-cysteine;
(C) lipids, injectable; and
(D) sodium phenylbutyrate;
(16) beta-blockers:
(A) Betaxolol;
(B) bisoprolol;
(C) carteolol;
(D) penbutolol; and
(E) propranolol XL;
(17) short-acting, inhaled beta 2 agonists:
(A) Metaproterenol inhaler;
(B) levalbuterol solution; and
(C) albuterol solutions: 0.021% and 0.042%;
(18) calcium channel blockers:
(A) Diltiazem extended release, with the following brand names:
(i) Cardizen SR®;
(ii) Cardizem CD®;
(iii) Cartia XT®;
(iv) Dilacor XR®;
(v) Taztia XT®; and
(vi) Cardizem LA®;
(B) verapamil sustained release, with the following brand names:
(i) Covera HS®; and
(ii) Verelan PM®;
(C) nifedipine sustained release, with the following brand names:
(i) Nifedical XL®; and
(ii) Procardia XL® and all generic equivalents;
(D) nisoldipine;
(E) felodipine;
(F) isradipine;
(G) nicardipine SR; and
(H) nifedipine immediate release, with the following brand names:
(i) Adalat® and all generic equivalents; and
(ii) Procardia® and all generic equivalents;
(19) fibric acid derivatives:
(A) Antara®; and
(B) Lofibra®;
(20) all growth hormones and growth hormone stimulating factor, including the following:
(A) Somatrem;
(B) somatropin;
(C) sermorelin; and
(D) mecasermin rinfabate;
(21) intranasal corticosteroids:
(A) Flunisolide; and
(B) beclomethasone;
(22) inhaled corticosteroids:
(A) Flunisolide-menthol;
(B) flunisolide; and
(C) budesonide inhaled suspension;
(23) proton pump inhibitors:
(A) Esomeprazole;
(B) omeprazole;
(C) omeprazole OTC;
(D) lansoprazole;
(E) pantoprazole;
(F) rabeprazole; and
(G) omeprazole $NaHCO_3$;
(24) monoclonal antibody for respiratory syncitial virus (RSV), including palivizumab;
(25) muscle relaxants:
(A) Tizanidine;
(B) orphenadrine;
(C) carisoprodol;
(D) carisoprodol-aspirin;
(E) carisoprodol-aspirin-caffeine;
(F) cyclobenzaprine;
(G) metaxolone;
(H) dantrolene; and
(I) orphenadrine-aspirin-caffeine;

(26) narcotics:
(A) Buprenorphine-naloxone; and
(B) buprenorphine;
(27) nonsteroidal, anti-inflammatory drugs: nabumetone;
(28) drugs for the treatment of obesity:
(A) Orlistat;
(B) sibutramine; and
(C) phentermine;
(29) oxazolidinones, including linezolid;
(30) HMG-CoA reductase inhibitors:
(A) Pravastatin;
(B) fluvastatin; and
(C) lovastatin;
(31) nonsedating antihistamines:
(A) Desloratidine; and
(B) fexofenadine;
(32) H_2 antagonists: nizatidine;
(33) triptans:
(A) Naratriptan;
(B) zolmitriptan; and
(C) frovatriptan;
(34) antidiabetic drugs:
(A) Glipizide XL;
(B) glipizide-metformin;
(C) repaglinide;
(D) acarbose;
(E) Glucophage XR®;
(F) Fortamet®;
(G) Glumetza®;
(H) exenatide; and
(I) pramlintide acetate;
(35) the following types of syringes, penfills, and cartridges of insulin:
(A) Humalog®;
(B) Humalog Mix®;
(C) Humulin R®;
(D) Humulin N®;
(E) Humulin 70/30®;
(F) Novolog®;
(G) Novolog Mix®;
(H) Novolin R®;
(I) Novolin N®;
(J) Novolin 70/30®; and
(K) Velosulin BR®;
(36) hypnotics:
(A) Zaleplon;
(B) zolpidem; and
(C) zolpidem CR;
(37) serotonin 5-HT_3 receptor antagonist antiemetics:
(A) Kytril®; and
(B) Anzemet®;
(38) influenza vaccines: Flumist®;
(39) the following drugs if specifically required by the physician, which shall require prior authorization to override maximum allowable cost (MAC) or federal upper limit (FUL) pricing:
(A) Clozaril;
(B) depakene;
(C) tegretol; and
(D) coumadin;
(40) monoclonal antibody for asthma: omalizumab;
(41) bisphosphonates:
(A) Risedronate; and
(B) risedronate-calcium;
(42) ACE inhibitors-calcium channel blockers:
(A) Enalapriol maleate-felodipine; and
(B) trandolapril-verapamil;
(43) ophthalmic prostaglandin analogues:
(A) Bimatoprost; and
(B) unoprostone;
(44) topical immunomodulators:
(A) Protpic® (topical formulation); and
(B) Elidel®;
(45) narcotic analgesics: any transmucosal form of fentanyl; and
(46) tramadol and all opioids, opioid combinations, and skeletal muscle relaxants, at any dose greater than the maximum recommended dose in a 31-day period.

(c) Failure to obtain prior authorization, if required, shall negate reimbursement for the service and any other service resulting from the unauthorized or noncertified treatment. The prior authorization shall affect reimbursement to all providers associated with the service.

(d) The only exceptions to prior authorization shall be the following:

(1) Emergencies. If certain surgeries and procedures that require prior authorization are performed in an emergency situation, the request for authorization shall be made within two working days after the service is provided.

(2) Situations in which services requiring prior authorization are provided and retroactive eligibility is later established. When an emergency occurs or when retroactive eligibility is established, prior authorization for that service shall be waived, and if medical necessity is documented, payment shall be made.

(e) Services requiring prior authorization shall be considered covered services within the scope of the program, unless the request for prior authorization is denied. (Authorized by K.S.A.

2007 Supp. 39-7,120 and K.S.A. 2007 Supp. 75-7412; implementing K.S.A. 2007 Supp. 39-7,120 and K.S.A. 2007 Supp. 39-7,121a; effective Oct. 28, 2005; amended June 2, 2006; amended Aug. 11, 2006; amended Nov. 17, 2006; amended March 16, 2007; amended Oct. 19, 2007; amended May 23, 2008.)

129-5-65. Filing limitations for medical claims. (a) Each provider shall submit all medical claims to the Kansas medical assistance program within 12 months from the date of service.

(b) Any provider may resubmit a denied claim for payment to the Kansas medical assistance program if the resubmission meets the following requirements:

(1) Is within 24 months from the date of service; and

(2) is in conformance with all billing requirements of the medicaid/medikan program.

(c) The Kansas medical assistance program shall reimburse only claims that are submitted in accordance with subsection (a) or with subsections (a) and (b).

(d) Each of the following claims shall be an exception to subsections (a) and (b) and shall be payable by the Kansas medical assistance program:

(1) Any claim that is submitted to medicare within 12 months from the date of service, is paid or denied for payment by medicare, and is subsequently received by the Kansas medical assistance program within 30 days from the date of medicare's payment or denial of payment;

(2) any claim determined by the Kansas health policy authority to be payable by reason of administrative appeals, court action, or agency error;

(3) any claim for emergency services rendered by an out-of-state provider who is not already enrolled as a program provider;

(4) any claim for services provided to a recipient that is submitted to the Kansas medical assistance program within 12 months from the date on which the agency issues a notice of action under K.A.R. 129-6-38; and

(5) any claim specified in paragraph (d) (1), (2), (3), or (4) that is not payable under that paragraph but that the Kansas health policy authority determines is the result of extraordinary circumstances. (Authorized by K.S.A. 2006 Supp. 75-7403 and 75-7412; implementing K.S.A. 2006 Supp. 75-7405 and 75-7408; effective July 13, 2007.)

129-5-78. Scope of and reimbursement for home- and community-based services for persons with traumatic brain injury. (a) The scope of allowable home- and community-based services (HCBS) for persons with traumatic brain injury shall consist of those services authorized by the applicable federally approved waiver to the Kansas medicaid state plan. Recipients of services provided pursuant to this waiver shall be capable of benefitting from rehabilitation by showing continuing improvement in their condition.

(b) The need for HCBS services shall be determined by an individualized assessment of the prospective recipient by a provider enrolled in the program. HCBS services shall be provided only in accordance with a plan of care written by a case manager.

(c) Mandatory HCBS services shall include transitional living skills training, up to a maximum of four hours each day, with a minimum of four hours each week and a maximum of 780 hours each year.

(d) Optional HCBS services, which shall require prior authorization by the Kansas medicaid HCBS program manager, may include one or more of the following:

(1) Rehabilitation therapies, which may consist of any of the following:

(A) Occupational therapy;

(B) physical therapy;

(C) speech-language therapy;

(D) cognitive rehabilitation;

(E) behavioral therapy; or

(F) drug or alcohol abuse therapy;

(2) personal services;

(3) medical equipment, supplies, and home modification not otherwise covered under the Kansas medicaid state plan;

(4) sleep-cycle support services; or

(5) a personal emergency response system and its installation.

(e) Case management services, up to a maximum of 160 hours each calendar year, which may be exceeded only with prior authorization by the Kansas medicaid HCBS program manager, shall be provided to all HCBS recipients under the traumatic brain injury program.

(f) The fee allowed for home- and community-based services for persons with traumatic brain injury shall be the provider's usual and customary charges, except that no fee shall be paid in excess of the waiver's range maximum. (Authorized by K.S.A. 2006 Supp. 75-7403 and 75-7412; implementing K.S.A. 2006 Supp. 75-7405 and 75-7408,

as amended by L. 2007, ch. 177, sec. 4; effective July 18, 2008.)

129-5-88. Scope of physician services. (a) Except as specified in subsection (b), the program shall cover medically necessary services recognized under Kansas law provided to program recipients by physicians who are licensed to practice medicine and surgery in the jurisdiction in which the service is provided.

(b) The following services shall be excluded from coverage under the program:

(1) Visits. The following types of visits shall be excluded:

(A) Office visits when the only service provided is an injection or some other service for which a charge is not usually made;

(B) psychotherapy services when provided concurrently by the same provider with both targeted case management services and partial hospitalization services;

(C) psychotherapy services exceeding an average of 32 hours of individual therapy or 32 hours of group therapy or any combination of these in a calendar year for each recipient, unless the recipient is a Kan Be Healthy program participant and either of these conditions is met:

(i) Psychotherapy services do not exceed 40 hours in a calendar year for each Kan Be Healthy program participant; or

(ii) psychotherapy services are being rendered pursuant to a plan approved by the agency. The provider of psychotherapy services shall obtain prior authorization for the plan. The plan shall not exceed a two-year period and shall be subject to a reimbursement limit established by the agency. Quarterly progress reports shall be submitted to the division of medical programs;

(D) inpatient hospital visits in excess of those allowable days for which the hospital is paid or would be paid if there were no spend-down requirements; and

(E) nursing home visits in excess of one each month, unless the service provider documents medical necessity.

(2) Consultations. The following types of consultations shall be excluded:

(A) Consultations for which there is no written report;

(B) inpatient hospital consultations in excess of one for each condition in a 10-day period, unless written documentation confirming medical necessity is attached to the claim; and

(C) consultations in excess of one for each condition in a 60-day period, unless written documentation confirming medical necessity is attached to the claim.

(3) Surgical procedures. The following types of surgical procedures and services shall be excluded:

(A) Procedures that are experimental, pioneering, cosmetic, or designated as noncovered;

(B) all transplant surgery, except for the following:

(i) Liver transplants, which shall be performed only at a hospital designated by the agency, unless the medical staff of that hospital recommends another location; and

(ii) corneal, heart, kidney, pancreas, and bone marrow transplants and related services;

(C) the services of a surgical assistant if the surgeon determines that an assistant is not required for a particular surgery; and

(D) elective surgery, except for sterilization operations or for Kan Be Healthy beneficiaries.

(4) Miscellaneous procedures. The following types of miscellaneous procedures shall be excluded:

(A) Diagnostic radiological and laboratory services, unless the services are medically necessary to diagnose or treat injury, illness, or disease;

(B) physical therapy, unless the following conditions are met:

(i) The therapy is performed by a physician or registered physical therapist under the direction of a physician; and

(ii) the therapy is prescribed by the attending physician;

(C) medical services of medical technicians, unless the technicians are under the direct supervision of a physician; and

(D) inpatient services that were provided on any day during a hospital stay and that are determined to not be medically necessary.

(5) Family planning services and materials.

(A) Family planning services and materials shall be excluded, unless all of the following conditions are met:

(i) The services are provided by a physician, family planning clinic, or county health department.

(ii) Written informed consent from the consumer is obtained as required by federal law and regulation.

(iii) The scope of services provided is in com-

pliance with applicable federal and state statutes and regulations.

(B) Reverse sterilizations shall be excluded.

(6) Concurrent care shall be excluded, unless both of the following conditions are met:

(A) The patient has two or more diagnoses involving two or more systems.

(B) The special skills of two or more physicians are essential in rendering quality medical care. The occasional participation of two or more physicians in the performance of one procedure shall be recognized. Each physician involved shall submit that physician's usual charge for only that portion of the procedure for which the physician is actually responsible.

(7) Psychological services for an individual entitled to receive these services as a part of care or treatment from a facility already being reimbursed by the program or by a third-party payor shall be excluded.

(c) The services provided by mid-level practitioners, including advanced registered nurse practitioners and physician assistants, shall be covered. (Authorized by L. 2005, Ch. 187, § 45 and K.S.A. 2005 Supp. 75-7403; implementing L. 2005, Ch. 187, § 41; effective Jan. 12, 2007.)

129-5-108. Scope of services for durable medical equipment, medical supplies, orthotics, and prosthetics. (a) Selected durable medical equipment (DME) shall be available to each beneficiary, with the following limitations:

(1) The DME shall be the most economical to meet the beneficiary's need.

(2) The least expensive and most appropriate method of delivery shall be used. If round-trip delivery is over 100 miles, prior authorization shall be required.

(3) Used equipment with a warranty specified by the agency shall be used if available.

(4) Certain DME designated by the agency shall be the property of the agency.

(5) Educational, environmental control, and convenience items shall not be covered.

(6) DME shall be covered for only the following types of beneficiaries:

(A) Participants in the Kan Be Healthy program;

(B) beneficiaries who require the DME for life support;

(C) beneficiaries who require the DME for employment; and

(D) beneficiaries who would require more expensive care if the DME was not provided.

(7) DME services provided for the parenteral administration of total nutritional replacements and intravenous medication in the beneficiary's home shall require the provision of services by a local home health agency, physician, advanced registered nurse practitioner, physician assistant, or pharmacist.

(b) Selected medical supplies shall be available to each beneficiary for use in the beneficiary's home.

(c) Selected DME and medical supplies shall be considered for coverage only in cases in which exceptional hardship or medical need has been justified by documentation of medical necessity or by the granting of prior authorization.

(d) Orthotics and prosthetics shall be available to program beneficiaries from orthotic and prosthetic dealers enrolled under K.A.R. 30-5-59. (Authorized by K.S.A. 2007 Supp. 75-7403 and 75-7412; implementing K.S.A. 2007 Supp. 75-7405 and 75-7408; effective Nov. 17, 2006; amended Sept. 19, 2008.)

129-5-118. Scope of federally qualified health center services. Federally qualified health center services and other ambulatory services shall be covered under the Kansas medical assistance program when the services are provided by a community health center approved by the health care financing administration to furnish federally qualified health center services for participation under medicare and medicaid. (a) The services provided by the following health care professionals shall be covered:

(1) Physician and physician assistant pursuant to K.A.R. 30-5-88;

(2) advanced registered nurse practitioner pursuant to K.A.R. 30-5-113;

(3) dentist pursuant to K.A.R. 30-5-100;

(4) clinical psychologist pursuant to K.A.R. 30-5-104;

(5) clinical social worker pursuant to K.A.R. 30-5-86;

(6) visiting nurse pursuant to K.A.R. 30-5-89; and

(7) for kan be healthy nursing assessments only, registered nurse pursuant to K.A.R. 30-5-87.

(b) Covered services shall also include the following:

(1) The services and supplies furnished as an incident to the professional services provided by

the health care professionals specified in subsection (a); and

(2) other ambulatory services covered under the medicaid state plan, if provided by the federally qualified health center.

(c) "Visiting nurse" shall include a registered nurse or licensed practical nurse who provides part-time or intermittent nursing care to a homebound patient at the beneficiary's place of residence under a written plan of treatment prepared by a physician. The place of residence shall not include a hospital or long-term care facility. This nursing care shall be covered only if there is no home health agency in the area. (Authorized by and implementing K.S.A. 2005 Supp. 75-7412; effective June 2, 2006.)

129-5-118b. Cost reimbursement principles for federally qualified health center services and other ambulatory services. The medicare cost reimbursement principles contained in 42 C.F.R. part 413, as revised on October 1, 2005 and hereby adopted by reference, and the cost principles, standards, and limits discussed in this regulation and in K.A.R. 30-5-118a shall be applicable to the financial and statistical data reported by the federally qualified health center for the determination of reasonable cost of providing covered services. (a) Nonreimbursable costs. Each cost that is not related to patient care and is not necessary for the efficient delivery of covered federally qualified health center services and other ambulatory services shall be excluded from the medicaid rate determination. In addition, the following expenses shall be considered nonreimbursable:

(1) Salaries and fees paid to nonworking directors and officers;

(2) uncollectible debts;

(3) donations and contributions;

(4) fund-raising expenses;

(5) taxes including the following:

(A) Those from which the provider is entitled to obtain exemption;

(B) those on property not used in providing covered services; and

(C) those levied against a patient and remitted by the provider;

(6) life insurance premiums for directors, officers, and owners;

(7) the imputed value of in-kind services rendered by nonpaid workers and volunteers;

(8) the cost of social, fraternal, civic, and other organizations associated with activities unrelated to patient care;

(9) all expenses related to vending machines;

(10) board of director costs;

(11) the cost of advertising for promoting the services offered by the facility to attract more patients;

(12) public relations and public information expenses;

(13) penalties, fines, and late charges, including interest paid on state and federal payroll taxes;

(14) the cost of items or services provided only to non-Kansas medical assistance program patients and reimbursed by third party payers;

(15) all expenses associated with the ownership, lease, or charter of airplanes;

(16) bank overdraft charges and other penalties;

(17) the cost associated with group health education classes, activities, and mass information programs including media productions, brochures, and other publications;

(18) expense items without indication of their nature or purpose including "other," "miscellaneous," and "consultation";

(19) non-arm's-length transactions;

(20) legal and other costs associated with litigation between a provider and state or federal agencies, unless litigation is decided in the provider's favor; and

(21) legal expenses not related to patient care.

(b) Costs allowed with limitations and conditions.

(1) Administrator and coadministrator compensation. Reasonable limits shall be applied by the agency based upon the current civil service salary schedule.

(2) Loan acquisition fees and standby fees. These fees shall be amortized over the life of the loan and shall be allowed only if the loan is related to patient care.

(3) Taxes associated with financing the operations. These taxes shall be allowed only as amortized cost.

(4) Special assessments on land for capital improvements. These assessments shall be amortized over the estimated useful life of the improvements and allowed only if related to patient care.

(5) Start-up costs of a new facility.

(A) Start-up costs may include the following:

(i) Staff salaries and consultation fees subject to the limitations specified in paragraph (b)(1);

(ii) utilities;
(iii) taxes;
(iv) insurance;
(v) mortgage interest;
(vi) employee training; and
(vii) any other allowable cost incidental to the operation of the facility.

(B) A start-up cost shall be recognized only if it meets the following criteria:

(i) Is incurred before the opening of the facility;

(ii) is related to developing the facility's ability to provide covered services;

(iii) is amortized over a period of 60 months or more;

(iv) is consistent with the facility's federal income tax return and financial reports, with the exception of paragraph (b)(5)(B)(iii); and

(v) is identified in the cost report as a start-up cost.

(6) Expenses. Each cost that can be identified as an organization expense or capitalized as a construction expense shall be appropriately classified and excluded from start-up costs.

(7) Payments made to related parties for services, facilities, and supplies. These payments shall be allowed at the lower of the actual cost to the related party and the market price.

(8) Premium payments. If a provider chooses to pay in excess of the market price for supplies or services, the agency shall use the market price to determine the allowable cost in the absence of a clear justification for the premium.

(9) Job-related training. The cost of this training shall be the actual amount minus any reimbursement or discount received by the provider.

(10) Lease payments. These payments shall be allowed only if reported in accordance with the generally accepted accounting principles appropriate to the reporting period.

(c) Interest expense. Only necessary and accurate interest on working capital indebtedness shall be an allowable cost.

(1) The interest expense shall be allowed only if it is established with either the following:

(A) Any lender or lending organization not related to the borrower; or

(B) the central office and other related parties under the following conditions:

(i) The terms and conditions of payment of the loans are on arm's-length basis with a recognized lending institution;

(ii) the provider demonstrates, to the satisfaction of the agency, a primary business purpose for the loan other than increasing the rate of reimbursement; and

(iii) the transaction is recognized and reported by all parties for federal income tax purposes.

(2) Interest expense shall be reduced by investment income from both restricted and unrestricted idle funds and funded reserve accounts, except when the income is from restricted or unrestricted gifts, grants, and endowments held in separate accounts with no commingling with other funds. Income from the provider's qualified pension fund shall not be used to reduce interest expense.

(3) Interest earned on restricted and unrestricted industrial revenue bond reserve accounts and sinking fund accounts shall be offset against interest expense up to and including the amount of the related interest expense.

(4) The interest expense on that portion of the facility acquisition loan attributable to an excess over historic cost or other cost basis recognized for program purposes shall not be considered a reasonable cost.

(d) Central office cost. This subsection shall be applicable in situations in which the federally qualified health center is one of several programs or departments administered by a central office or organization and the total administrative cost incurred by the central office is allocated to all components.

(1) Allocation of the central office cost shall use a logical and equitable basis and shall conform to generally accepted accounting procedures.

(2) The central office cost allocated to the federally qualified health center shall be allowed only if the amount is reasonable and if the central office provided a service normally available in similar facilities enrolled in the program.

(3) The provider shall bear the burden of furnishing sufficient evidence to establish the reasonability of the level of allocated cost and the nature of services provided by the central office.

(4) All costs incurred by the central office shall be allocated to all components as a central cost pool, and no portion of the central office cost shall be directed to individual facilities operated by the provider or reported on any line of the cost report other than the appropriate line of the central office cost on any other line of the cost report outside of the central office cost allocation plan.

(5) Only patient-related central office costs

shall be recognized, which shall include the following:

(A) Cost of ownership or arm's-length rent or lease expense for office space;

(B) utilities, maintenance, housekeeping, property tax, insurance, and other facility costs;

(C) employee salaries and benefits;

(D) office supplies and printing;

(E) management consultant fees;

(F) telephone and other means of communication;

(G) travel and vehicle expenses;

(H) allowable advertising;

(I) licenses and dues;

(J) legal costs;

(K) accounting and data processing; and

(L) interest expense.

(6) The cost principles and limits specified in this regulation shall also apply to central office costs.

(7) Estimates of central office costs shall not be allowed. (Authorized by and implementing K.S.A. 2005 Supp. 75-7412; effective June 2, 2006.)

Article 6.—MEDICAL ASSISTANCE PROGRAM—CLIENTS' ELIGIBILITY FOR PARTICIPATION

129-6-38. Rights of applicants and recipients. (a) Right to information. Each applicant or recipient shall have the right to be provided with information concerning the types of assistance that are provided by the agency. Upon request, each applicant shall be furnished with information by the agency, and the categories of assistance and the eligibility factors shall be explained to the applicant.

(b) Right to submit an application. Each applicant shall have the right to submit an application regardless of any question of eligibility or agency responsibility. The right of any individual to submit an application shall not be abridged.

(c) Right to private interview. Each individual, upon request, shall have the right to a private interview when discussing individual situations with the agency.

(d) Right to a determination of eligibility for assistance. Each applicant or recipient shall be given an opportunity to present any request and to explain the applicant's or recipient's situation.

(e) Right to withdraw from program. Each applicant shall have the right to withdraw the application at any time between the date the application is signed and the date the notice of the agency's decision is mailed. Any recipient may withdraw from a program at any time.

(f) Right to a prompt decision. Each applicant shall have the right to have a decision rendered on an application within 45 days of its receipt by the agency or within 90 days of receipt for disability determination cases. Each recipient shall have the right to have a decision rendered on any formal request within 30 days of its receipt by the agency.

(g) Right to the correct amount of assistance. Each individual, if eligible, shall be entitled to the correct amount of assistance, based upon the program regulations.

(h) Right to written notification of action. Each individual shall have the right to a written notification of agency action concerning eligibility for the medical assistance program. For children eligible for presumptive coverage as specified in K.A.R. 129-6-151, the notice shall be sent from the qualified entity as required in K.A.R. 129-6-152.

(i) Right to equal treatment. Each individual shall have the right to be treated in the same manner as that for other individuals who are in similar circumstances.

(j) Right to a fair hearing. Except for children for whom a determination under presumptive medical assistance as defined in K.A.R. 129-6-151 has been made, each individual shall have the right to request a fair hearing if the individual is dissatisfied with any agency decision or lack of action in regard to the application for or the receipt of assistance. (Authorized by K.S.A. 2005 Supp. 75-7412; implementing K.S.A. 2005 Supp. 75-7412 and 75-7413, as amended by L. 2006, ch. 4, § 2; effective Aug. 11, 2006.)

129-6-77. Poverty-level pregnant women and children; determined eligibles. Each applicant or recipient shall meet the general eligibility requirements of K.A.R. 30-6-50 and the specific eligibility requirements in this regulation. (a) Pregnant women. Each eligible woman shall be medically determined to be pregnant. Assistance under this regulation shall continue for two calendar months following the month in which the pregnancy terminates.

(b) Infants. Each eligible infant shall be under one year of age. Assistance under this regulation

shall continue according to either of the following provisions:

(1) Through the month in which the child turns age one; or

(2) if receiving inpatient services in the month in which the child turns age one, according to the earlier of the following:

(A) Through the calendar month in which the inpatient care ends; or

(B) through the calendar month following the month in which the inpatient care begins.

If the inpatient care will exceed either of these time periods, eligibility for the child under this regulation shall end on the last day of the calendar month in which the child turns age one.

(c) Other young children. Each eligible child shall be at least one year of age, but no older than five years of age. Assistance under this regulation shall continue according to either of the following provisions:

(1) Through the month in which the child turns age six; or

(2) if receiving inpatient services in the month in which the child turns age six, according to the earlier of the following:

(A) Through the calendar month in which the inpatient care ends; or

(B) through the calendar month following the month in which the inpatient care begins. If the inpatient care will exceed this time period, eligibility for the child under this regulation shall end on the last day of the calendar month in which the child turns age six.

(d) Older children. Each eligible child shall be at least six years of age but under the age of 19 and shall be born on or after October 1, 1979.

(e) Persons whose needs are to be considered in determining eligibility.

(1) For pregnant women, the needs of the pregnant woman, the unborn child, and the father, if living with the pregnant woman, shall be considered. If the pregnant woman is a minor and lives with her parents, the needs of her parents shall also be considered.

(2) For all children, if the child lives with a parent or parents, the needs of the child and the child's parents shall be considered.

(3) Other pregnant women and children in the family group for whom assistance is requested shall be considered in the assistance plan if otherwise eligible.

(f) Financial eligibility. A percentage of the official federal poverty income guidelines as established in K.A.R. 30-6-103 shall be used as the protected income level for the number of persons in the plan and any other persons in the family whose income is being considered. The total applicable income to be considered in the eligibility base period shall be compared against the poverty level for the base period. To be eligible under this provision, the total applicable income shall not exceed the poverty level established for the base period. Ownership of excess nonexempt real or personal property shall not result in ineligibility.

(g) Continuous eligibility. Each pregnant woman who becomes eligible for assistance under this regulation shall continue to be eligible throughout her pregnancy and the two calendar months following the month in which her pregnancy terminates, without regard to any changes in family income. Except for children determined eligible for presumptive medical assistance as specified in K.A.R. 129-6-151, each child who becomes eligible for assistance under this regulation shall continue to be eligible for 12 months beginning with the first month of assistance, without regard to any changes in family income. (Authorized by and implementing K.S.A. 2005 Supp. 75-7412; effective June 30, 2006.)

129-6-151. Presumptive eligibility. (a) Each individual under age 19 shall be eligible for a presumptive period if a qualified entity, as specified in K.A.R. 129-6-152, designated by the agency determines that the individual meets the presumptive eligibility requirements.

(b) The individual shall be under age 19 and meet the standard for a determined eligible in K.A.R. 129-6-77(b)(1), (c)(1), or (d). The individual shall meet the financial requirements in K.A.R. 129-6-77(f) and K.A.R. 129-6-77(e)(2) and (3). The individual shall also meet the general eligibility requirements of K.A.R. 30-6-52 and K.A.R. 30-6-54.

(c) The presumptive period shall begin on the date on which the qualified entity makes an eligibility determination. The presumptive period shall end on the last day of the month following the month in which the determination is made, unless an application for medical assistance is received. If an application is filed in accordance with K.A.R. 30-6-65 before this date, the presumptive period shall end on the last day of the month in which a full determination is made according to this article.

(d) Each individual shall be eligible for only one

period of presumptive eligibility within a 12-month period under this article or under K.A.R. 129-14-51. The 12-month period shall begin on the first day of presumptive eligibility under either article. (Authorized by and implementing K.S.A. 2005 Supp. 75-7412; effective June 30, 2006.)

129-6-152. Presumptive eligibility to be determined by qualified entities. (a) Each qualified entity shall be designated by the agency to make determinations of presumptive eligibility as specified in K.A.R. 129-6-151.

(b) Each qualified entity shall be authorized to provide health care items and services and to receive reimbursement for these items and services under the medical assistance program.

(c) For each determination of presumptive eligibility, a qualified entity shall perform the following:

(1) Make a finding of presumptive eligibility pursuant to K.A.R. 129-14-51(b) or 129-6-151(b);

(2) notify the child's parent or caretaker, in writing, of the results of the determination at the time of the determination;

(3) provide the parent or caretaker with an application for regular medical assistance. For a child determined to be presumptively eligible, the qualified entity shall notify the child's parent or caretaker that a regular medicaid application shall be required to be submitted before the last day of the month following the month of the presumptive determination or eligibility shall end on that date;

(4) assist the child's parent or caretaker in completing and filing a regular medical assistance application; and

(5) notify the agency of the presumptive determination within five working days after the determination. (Authorized by and implementing K.S.A. 2005 Supp. 75-7412; effective June 30, 2006.)

Article 7.—APPEALS, FAIR HEARINGS AND TAF/GA DISQUALIFICATION HEARINGS

129-7-65. Notice to recipients of intended action. (a) (1) "Adequate notice" shall mean a written notice that includes a statement of what action the agency intends to take, the reasons for the intended agency action, the specific policies supporting the action, an explanation of the individual's right to request a hearing, and the circumstances under which assistance is continued if a hearing is requested.

(2) "Timely" shall mean that a notice is mailed at least 10 days, including Saturdays, Sundays, and legal holidays, before the date upon which the action that is the subject of the notice would become effective.

(b) When the agency intends to take action to discontinue, terminate, suspend, or reduce assistance, timely and adequate notice shall be given by the agency, except as specified in subsections (c) and (d) of this regulation.

(c) Under any of following circumstances, timely notice shall not be required, but an adequate notice shall be sent by the agency not later than the date of action:

(1) The agency has factual information confirming the death of a recipient.

(2) The agency receives a clear, written statement signed by a recipient that the recipient no longer wishes assistance or that provides information requiring termination or reduction of assistance, and the recipient has indicated, in writing, an understanding that termination or reduction of assistance will be the consequence of supplying the information.

(3) The recipient has been admitted or committed to an institution, and further payments to that individual are not authorized by program regulations as long as the person resides in the institution.

(4) The recipient has been placed in a skilled nursing facility, an intermediate care facility, or a long-term care facility.

(5) The recipient's whereabouts are unknown, and agency mail directed to the recipient has been returned by the post office indicating no known forwarding address.

(6) The agency has established that a recipient has been accepted for assistance in a new jurisdiction.

(7) A child is removed from the home as a result of a judicial determination or has been voluntarily placed in foster care by the child's legal guardian.

(8) A change in the level of medical care is prescribed by the recipient's physician.

(9) A special allowance granted for a specific period is terminated, and the recipient was informed in writing when the allowance was granted that it would automatically terminate at the end of the specified period.

(10) The agency takes action because of in-

formation that the recipient furnished in a status report or because the recipient has failed to submit a complete or a timely status report.

(11) The recipient is disqualified due to fraud through any of the following:

(A) A court of appropriate jurisdiction;

(B) a disqualification hearing process in accordance with K.A.R. 30-7-102; or

(C) a waiver of an administrative disqualification hearing in accordance with K.A.R. 30-7-103.

(d) When the agency takes action to discontinue, terminate, suspend, or reduce medical coverage for a child who has been determined eligible for presumptive medical assistance as specified in K.A.R. 129-6-151 or K.A.R. 129-14-152, neither timely nor adequate notice shall be required. (Authorized by and implementing K.S.A. 2005 Supp. 75-7412; effective June 30, 2006.)

Article 10.—ADULT CARE HOME PROGRAM

129-10-15a. Reimbursement. (a) Each provider with a current signed provider agreement shall be paid a per diem rate for services furnished to Kansas medical assistance-eligible residents. Payment shall be for the type of medical or health care required by the resident, as determined by the attending physician's or physician extender's certification upon admission, and the individual's level of care needs, as determined through assessment and reassessment. However, payment for services shall not exceed the type of care that the provider is certified to provide under the Kansas medical assistance program. The type of care required by the resident may be verified by the agency before and after payment.

(b) Payment for routine services and supplies, pursuant to K.A.R. 30-10-1a, shall be included in the per diem reimbursement. No provider shall otherwise bill or be reimbursed for these services and supplies.

(1) The durable medical equipment, medical supplies, and other items and services specified in paragraphs (b)(1)(A) through (OOO) shall be considered routine for each resident to attain and maintain the highest practicable physical and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. No provider shall bill or be reimbursed for the following separately from the per diem rate:

(A) Alternating pressure pads and pumps;

(B) armboards;

(C) bedpans, urinals, and basins;

(D) bed rails, beds, mattresses, and mattress covers;

(E) blood glucose monitors and supplies;

(F) canes;

(G) commodes;

(H) compressors;

(I) crutches;

(J) denture cups;

(K) dialysis, including supplies and maintenance, if the service is provided in the facility by facility staff;

(L) dressing items, including applicators, tongue blades, tape, gauze, bandages, adhesive bandages, pads, compresses, elasticized bandages, petroleum jelly gauze, cotton balls, slings, triangle bandages, pressure pads, and tracheostomy care kits;

(M) emesis basins and bath basins;

(N) enemas and enema equipment;

(O) extra nursing care and supplies;

(P) facial tissues and toilet paper;

(Q) first-aid ointments and similar ointments;

(R) footboards;

(S) foot cradles;

(T) gel pads or cushions;

(U) geriatric chairs;

(V) gloves, rubber or plastic;

(W) heating pads;

(X) heat lamps and examination lights;

(Y) humidifiers;

(Z) ice bags and hot water bottles;

(AA) intermittent positive-pressure breathing (IPPB) machines;

(BB) irrigation solution, both water and normal saline;

(CC) IV stands, clamps, and tubing;

(DD) laundry, including personal laundry;

(EE) laxatives;

(FF) lifts;

(GG) lotions, creams, and powders, including baby lotion, oil, and powders;

(HH) maintenance care for residents who have head injuries;

(II) mouthwash;

(JJ) nebulizers;

(KK) nonemergency transportation;

(LL) nutritional supplements;

(MM) occupational therapy;

(NN) orthoses and splints to prevent or correct contractures;

(OO) over-the-counter analgesics and antacids

taken for the occasional relief of pain or discomfort, as needed;

(PP) over-the-counter vitamins;

(QQ) oxygen, masks, stands, tubing, regulators, hoses, catheters, cannulae, humidifiers, concentrators, and canisters;

(RR) parenteral and enteral infusion pumps;

(SS) patient gowns, pajamas, and bed linens;

(TT) physical therapy;

(UU) respiratory therapy;

(VV) restraints;

(WW) sheepskins and foam pads;

(XX) skin antiseptics, including alcohol;

(YY) speech therapy;

(ZZ) sphygmomanometers, stethoscopes, and other examination equipment;

(AAA) stool softeners;

(BBB) stretchers;

(CCC) suction pumps and tubing;

(DDD) syringes and needles;

(EEE) thermometers;

(FFF) traction apparatus and equipment;

(GGG) underpads and adult diapers, disposable or nondisposable;

(HHH) walkers;

(III) water pitchers, glasses, and straws;

(JJJ) weighing scales;

(KKK) wheelchairs;

(LLL) urinary supplies, urinary catheters, and accessories;

(MMM) total nutritional replacement therapy;

(NNN) gradient compression stockings; and

(OOO) ostomy supplies.

(2) Each nursing facility shall provide at no cost to residents over-the-counter drugs, supplies, and personal comfort items that meet these criteria:

(A) Are available without a prescription at a commercial pharmacy or medical supply outlet; and

(B) are provided by the facility as a reasonable accommodation for individual needs and preferences. These over-the-counter products shall be included in the nursing facility cost report. A nursing facility shall not be required to stock all products carried by vendors in the nursing facility's community that are viewed as over-the-counter products.

(3) Occupational, physical, respiratory, speech, and other therapies. The Kansas medical assistance program cost of therapies shall be determined as follows:

(A) Compute the medicaid therapy ratio as the total number of medicaid therapy units not otherwise reimbursed to the total number of therapy units provided to all nursing facility residents during the cost report period;

(B) multiply the medicaid therapy ratio by the total reported therapy costs to determine the allowable medicaid portion of therapy costs;

(C) multiply the allowable medicaid portion of the therapy costs by the ratio of the total number of days to the number of medicaid resident days to determine the allowable therapy expenses for the cost report period;

(D) offset the nonallowable portion of the therapy cost in the provider adjustment column and on the related therapy expense line in the cost report; and

(E) submit a work paper with the cost report that supports the calculation of the allowable Kansas medical assistance program therapy expenses determined in accordance with paragraphs (b)(5)(A) through (C).

(c) Each provider of ancillary services, as defined in K.A.R. 30-10-1a, shall bill separately for each service when the services or supplies are required.

(d) Payment for specialized rehabilitative services or active treatment programs shall be included in the per diem reimbursement.

(e) Payment shall be limited to providers who accept, as payment in full, the amount paid in accordance with the fee structure established by the Kansas medical assistance program.

(f) Payment shall not be made for allowable, nonroutine services and items unless the provider has obtained prior authorization.

(g) Private rooms for recipients shall be provided if medically necessary or, if not medically necessary, at the discretion of the facility. If a private room is not medically necessary or is not occupied at the discretion of the facility, then a family member, guardian, conservator, or other third party may pay the incremental difference that would be charged to a private-pay resident to move from a semiprivate room to a private room. (Authorized by K.S.A 2007 Supp. 75-7403 and 75-7412; implementing K.S.A. 2007 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008.)

129-10-15b. Financial data. (a) General. The per diem rate or rates for providers participating in the Kansas medical assistance program shall be based on an audit or desk review of the costs reported to provide resident care in each facility. The basis for conducting these audits or

reviews shall be form MS-2004, as adopted by reference in K.A.R. 129-10-17. Each provider shall maintain sufficient financial records and statistical data for proper determination of reasonable and adequate rates. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the nursing facility and related fields shall be followed, except to the extent that they conflict with or are superseded by state or federal medicaid requirements. Changes in these practices and systems shall not be required in order to determine reasonable and adequate rates.

(b) Cost reports. Pursuant to K.A.R. 129-10-17, cost reports shall be required from providers on an annual basis.

(c) Adequate cost data and cost findings. Each provider shall provide adequate cost data on the cost report. This cost data shall be in accordance with state and federal medicaid requirements and general accounting rules and shall be based on the accrual basis of accounting. Estimates of costs shall not be allowable except on projected cost reports submitted pursuant to K.A.R. 129-10-17.

(d) Recordkeeping requirements.

(1) Each provider shall furnish any information to the agency that is necessary to meet these criteria:

(A) To ensure proper payment by the program pursuant to paragraph (d)(2);

(B) to substantiate claims for program payments; and

(C) to complete determinations of program overpayments.

(2) Each provider shall permit the agency to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of program payments due. These records shall include the following:

(A) Documentation of the nursing facility ownership, organization, and operation, including documentation as to whether transactions occurred between related parties;

(B) fiscal, medical, and other documents;

(C) federal and state income tax returns and all supporting documents;

(D) documentation of asset acquisition, lease, sale, or other action;

(E) documentation of franchise or management arrangements;

(F) documentation pertaining to costs of operations;

(G) a record of the amounts of income received, by source and purpose; and

(H) a statement of changes in financial position.

(3) Other records and documents shall be made available as necessary.

(4) Records and documents shall be made available in Kansas.

(5) Each provider, when requested, shall furnish the agency with copies of resident service charge schedules and changes to these charge schedules as they are put into effect. The charge schedules shall be evaluated by the agency to determine the extent to which the schedules may be used for determining program payment.

(6) Suspension of program payments may be made if the agency determines that any provider does not maintain or no longer maintains adequate records for the determination of reasonable and adequate per diem rates under the program or the provider fails to furnish requested records and documents to the agency. Payments to that provider may be suspended.

(7) Thirty days before suspending payment to the provider, written notice shall be sent by the agency to the provider of the agency's intent to suspend payments, except as provided in paragraph(e)(2). The notice shall explain the basis for the agency's determination with respect to the provider's records and shall identify the provider's recordkeeping deficiencies.

(8) All records of each provider that are used in support of costs, charges, and payments for services and supplies shall be subject to inspection and audit by the agency, the United States department of health and human services, and the United States general accounting office. All financial and statistical records used to support cost reports shall be retained for five years following the last day on which rates determined from those cost reports are effective.

(e) Desk review requirement.

(1) Each provider shall submit all information requested by the agency that is necessary to complete the desk review of the cost report.

(2) If a provider does not submit the information deemed necessary by the agency to complete the desk review of the cost report for a nursing facility, the provider shall be notified in writing by the agency that the provider has 10 working days from the date of this notice to submit the required information, or the Kansas medical assistance program payments shall be suspended for the nursing facility. (Authorized by K.S.A. 2007 Supp. 75-

7403 and 75-7412; implementing K.S.A. 2007 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008.)

129-10-17. Cost reports. (a) Historical cost data.

(1) For cost reporting purposes, each provider shall submit the "nursing facility financial and statistical report," form MS-2004, revised August 2004 and hereby adopted by reference, completed in accordance with the accompanying instructions. The MS-2004 cost report shall be submitted on diskette, using software designated by the agency for cost report periods ending on or after December 31, 1999.

(2) Each provider who has operated a facility for 12 or more months on December 31 shall file the nursing facility financial and statistical report on a calendar year basis.

(b) Projected cost data.

(1) Projected cost reports.

(A) If a provider is required to submit a projected cost report under K.A.R. 129-10-18 (c) or (e), the provider's rate shall be based on a proposed budget with costs projected on a line item basis.

(B) The projected cost report for each provider who is required to file a projected cost report shall begin according to either of the following schedules:

(i) On the first day of the month in which the nursing facility was certified by the state licensing agency if that date is on or before the 15th of the month; or

(ii) on the first day of the following month if the facility is certified by the state licensing agency on or after the 16th but on or before the 31st of the month.

(C) The projected cost report shall end on the last day of the 12-month period following the date specified in paragraph (b)(1)(B), except under either of the following:

(i) The projected cost report shall end on December 31 if that date is not more than one month before or after the end of the 12-month period.

(ii) The projected cost report shall end on the provider's normal fiscal year-end used for the internal revenue service if that date is not more than one month before or after the end of the 12-month period and the criteria in K.A.R. 129-10-18 for filing the projected cost report ending on December 31 do not apply.

(D) The projected cost report period shall cover a consecutive period of time not less than 11 months and not more than 13 months.

(E) The projected cost report shall be reviewed for reasonableness and appropriateness by the agency. The projected cost report items that are determined to be unreasonable shall be disallowed before the projected rate is established.

(2) Projected cost reports for each provider with more than one facility.

(A) Each provider who is required to file a projected cost report in accordance with this subsection and who operates more than one facility, either in state or out of state, shall allocate central office costs to each facility that is paid rates from the projected cost data. The provider shall allocate the central office cost at the end of the provider's fiscal year or the calendar year that ends during the projection period.

(B) The method of allocating central office costs to those facilities filing projected cost reports shall be consistent with the method used to allocate the costs to those facilities in the chain that are filing historical cost reports.

(c) Amended cost reports.

(1) Each provider shall submit an amended cost report revising cost report information previously submitted if an error or omission is identified that is material in amount and results in a change in the provider's rate of $.10 or more per resident day.

(2) An amended cost report shall not be allowed after 13 months have passed since the last day of the year covered by the report.

(d) Due dates of cost reports.

(1) Each calendar year cost report shall be received not later than the close of business on the last working day of February following the year covered by the report.

(2) A historical cost report covering a projected cost report period shall be received by the agency not later than the close of business on the last working day of the second month following the close of the period covered by the report.

(3) Each cost report approved for a filing extension in accordance with subsection (e) shall be received not later than the close of business on the last working day of the month approved for the extension request.

(e) Extension of time for submitting a cost report.

(1) A one-month extension of the due date for the filing of a cost report may be granted by the agency if the cause for delay is beyond the control

of the provider. The causes for delay beyond the control of the provider that may be considered by the agency in granting an extension shall include the following:

(A) Disasters that significantly impair the routine operations of the facility or business;

(B) destruction of records as a result of a fire, flood, tornado, or another accident that is not reasonably foreseeable; and

(C) computer viruses that impair the accurate completion of cost report information.

(2) The provider shall make the request in writing. The request shall be received by the agency on or before the due date of the cost report. Requests received after the due date shall not be accepted.

(3) A written request for a second one-month extension may be granted by the Kansas medical assistance program director if the cause for further delay is beyond the control of the provider. The request shall be received by the agency on or before the due date of the cost report, or the request shall not be approved.

(f) Penalty for late filing. Each provider filing a cost report after the due date shall be subject to the following penalties:

(1) If the complete cost report has not been received by the agency by the close of business on the due date, all further payments to the provider shall be suspended until the complete cost report has been received. A complete cost report shall include all the required documents listed in the cost report.

(2) Failure to submit the cost report within one year after the end of the cost report period shall be cause for termination from the Kansas medical assistance program.

(g) Balance sheet requirement. Each provider shall file a balance sheet prepared in accordance with cost report instructions as part of the cost report forms for each provider.

(h) Working trial balance requirement. Each provider shall submit a working trial balance with the cost report. The working trial balance shall contain account numbers, descriptions of the accounts, the amount of each account, and the cost report expense line on which the account was reported. Revenues and expenses shall be grouped separately and totaled on the working trial balance and shall reconcile to the applicable cost report schedules. A schedule that lists all general ledger accounts grouped by cost report line number shall be attached.

(i) Allocation of hospital costs. An allocation of expenditures between the hospital and the long-term care unit facility shall be submitted through a step-down process prescribed in the cost report instructions.

(j) Interest documentation requirement. A signed promissory note and loan amortization schedule shall be submitted with the cost report for all fixed-term loan agreements with interest reported in the operating cost center. For working capital loans for one year or less, amortization schedules shall not be required. (Authorized by K.S.A. 2007 Supp. 75-7403 and 75-7412; implementing K.S.A. 2007 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008.)

129-10-18. Rates of reimbursement. (a) Rates for existing nursing facilities.

(1) The determination of per diem rates shall be made, at least annually, using base-year cost information submitted by the provider and retained for cost auditing and analysis.

(A) The base year utilized for cost information shall be reestablished at least once every seven years.

(B) A factor for inflation may be applied to the base-year cost information.

(C) For each provider currently in new enrollment, reenrollment, or change of ownership status, the base year shall be determined in accordance with subsections (c), (d), and (e), respectively.

(2) Per diem rates shall be limited by cost centers, except where there are special level-of-care facilities approved by the United States department of health and human services. The upper payment limits shall be determined by the median in each cost center plus a percentage of the median, using base-year cost information. The percentage factor applied to the median shall be determined by the agency.

(A) The cost centers shall be as follows:

(i) Operating;

(ii) indirect health care; and

(iii) direct health care.

(B) The property component shall consist of the real and personal property fee as specified in K.A.R. 129-10-25.

(C) The upper payment limit for the direct health care cost center shall be a statewide base limit calculated on each facility's base-year costs adjusted for case mix.

(i) A facility-specific, direct health care cost

center upper payment limit shall be calculated by adjusting the statewide base limit by that facility's average case mix index.

(ii) Resident assessments used to determine additional reimbursement for ventilator-dependent residents shall be excluded from the calculation of the facility's average case mix index.

(3) Each provider shall receive an adjusted rate for each quarter if there is a change from the previous quarter in the facility's average medicaid case mix index.

(4) Resident assessments that cannot be classified shall be assigned to the lowest case mix index.

(5) To establish a per diem rate for each provider, a factor for incentive may be added to the allowable per diem cost.

(6)(A) Resident days shall be determined from census information corresponding to the base-year cost information submitted by the provider.

(B) The total number of resident days shall be used to calculate the per diem costs used to determine the upper payment limit and rates in the direct health care cost center. The total number of resident days shall be used to calculate the per diem costs used to determine the upper payment limit and rates for food and utilities in the indirect health care cost center.

(C) For homes with more than 60 beds, the number of resident days used to calculate the upper payment limits and rates in the operating cost center and indirect health care cost center, less food and utilities, shall be subject to an 85 percent minimum occupancy requirement based on the following:

(i) Each provider that has been in operation for 12 months or longer and has an occupancy rate of less than 85 percent for the cost report period shall have the number of resident days calculated at the minimum occupancy of 85 percent.

(ii) The 85 percent minimum occupancy requirement shall be applied to the number of resident days and costs reported for the 13th month of operation and after. The 85 percent minimum occupancy requirement shall be applied to the interim rate of a new provider, unless the provider is allowed to file a projected cost report.

(iii) The minimum occupancy rate shall be determined by multiplying the total number of licensed beds by 85 percent. In order to participate in the Kansas medical assistance program, each nursing facility provider shall obtain proper certification for all licensed beds.

(iv) Each provider with an occupancy rate of 85 percent or greater shall have actual resident days for the cost report period used in the rate computation.

(7) Each provider shall be given a detailed listing of the computation of the rate determined for the provider's facility.

(8) The effective date of the rate for existing providers shall be in accordance with K.A.R. 30-10-19.

(b) Rate limitations based on comparable service private-pay charges.

(1) For each nursing facility and nursing facility for mental health, the per diem rate for care shall not exceed the rate charged for the same type of service to residents who are not under the Kansas medical assistance program. Private-pay rates reported to the agency on other than a per diem basis shall be converted to a per diem equivalent.

(2) The agency shall maintain a registry of private-pay per diem rates submitted by providers.

(A) Each provider shall notify the agency of any change in the private-pay rate and the effective date of that change so that the registry can be updated.

(i) Private-pay rate information submitted with the cost reports shall not constitute notification and shall not be acceptable.

(ii) Providers may send private-pay rate notices by certified mail so that there is documentation of receipt by the agency.

(B) The private-pay rate registry shall be updated based on the notification from the providers.

(C) The effective date of the private-pay rate in the registry shall be the later of the effective date of the private-pay rate or the first day of the following month in which complete documentation of the private-pay rate is received by the agency.

(i) If the effective date of the private-pay rate is other than the first day of the month, the effective date in the registry shall be the first day of the closest month. If the effective date is after the 15th, the effective date in the register shall be the first day of the following month.

(ii) For new facilities or new providers coming into the medicaid program, the effective date of the private-pay rate shall be the date on which certification is issued.

(3) The average private-pay rate for comparable services shall be included in the registry. The average private pay rate may consist of the following variables:

(A) Room rate differentials. The weighted av-

erage private-pay rate for room differentials shall be determined as follows:

(i) Multiply the number of private-pay residents in private rooms, semiprivate rooms, wards, and all other room types by the rate charged for each type of room. Sum the resulting products of each type of room. Divide the sum of the products by the total number of private pay residents in all rooms. The result, or quotient, is the weighted average private-pay rate for room differentials.

(ii) Each provider shall submit documentation to show the calculation of the weighted average private-pay rate if there are room rate differentials.

(iii) Failure to submit the documentation shall limit the private-pay rate in the registry to the semiprivate room rate.

(B) Level-of-care rate differentials. The weighted average private-pay rate for level-of-care differentials shall be determined as follows:

(i) Multiply the number of private-pay residents in each level of care by the rate they are charged to determine the product for each level of care. Sum the products for all of the levels of care. Divide the sum of the products by the total number of private-pay residents in all levels of care. The result, or quotient, is the weighted average private-pay rate for the level-of-care differentials.

(ii) Each provider shall submit documentation to show the calculation of the weighted average rate when there are level-of-care rate differentials.

(iii) Failure to submit the documentation may delay the effective date of the average private-pay rate in the registry until the complete documentation is received.

(C) Extra charges to private-pay residents for items and services may be included in the weighted average private-pay rate if the same items and services are allowable in the Kansas medical assistance program rate.

(i) Each provider shall submit documentation to show the calculation of the weighted average extra charges.

(ii) Failure to submit the documentation may delay the effective date of the weighted average private-pay rate in the registry until the complete documentation is received.

(4) The weighted average private-pay rate shall be based on what the provider receives from the resident. If the private-pay charges are consistently higher than what the provider receives from the residents for services, then the average private-pay rate for comparable services shall be based on what is actually received from the residents. The weighted average private-pay rate shall be reduced by the amount of any discount received by the residents.

(5) The private-pay rate for medicare skilled beds shall not be included in the computation of the average private-pay rate for nursing facility services.

(6) When providers are notified of the effective date of the Kansas medical assistance program rate, the following procedures shall be followed:

(A) If the private-pay rate indicated on the agency register is lower, then the Kansas medical assistance program rate, beginning with its effective date, shall be calculated as follows:

(i) If the average medicaid case mix index is greater than the average private-pay case mix index, the Kansas medical assistance program rate shall be the lower of the private-pay rate adjusted to reflect the medicaid case mix or the calculated Kansas medical assistance rate.

(ii) If the average medicaid case mix index is less than or equal to the average private-pay case mix index, the Kansas medical assistance program rate shall be the average private-pay rate.

(B) Providers who are held to a lower private pay rate and subsequently notify the agency in writing of a different private-pay rate shall have the Kansas medical assistance program rate adjusted on the later of the first day of the month following the date upon which complete private-pay rate documentation is received or the effective date of a new private-pay rate.

(c) Rate for new construction or a new facility to the program.

(1) The per diem rate for any newly constructed nursing facility or a new facility to the Kansas medical assistance program shall be based on a projected cost report submitted in accordance with K.A.R. 129-10-17.

(2) The cost information from the projected cost report and the first historic cost report covering the projected cost report period shall be adjusted to the base-year period.

(3) The provider shall remain in new enrollment status until the base year is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider.

(4) Each factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in new enrollment status.

(5) No rate shall be paid until a nursing facility

financial and statistical report is received and processed to determine a rate.

(d) Change of provider.

(1) The payment rate for the first 24 months of operation shall be based on the base-year historical cost data of the previous owner or provider. If base-year data is not available, data for the most recent calendar year available preceding the base-year period shall be adjusted to the base-year period and used to determine the rate. If the 85 percent minimum occupancy requirement was applied to the previous provider's rate, the 85 percent minimum occupancy requirement shall also be applied to the new provider's rate.

(2) Beginning with the first day of the 25th month of operation, the payment rate shall be based on the historical cost data for the first calendar year submitted by the new provider. The data shall be adjusted to the base-year period.

(3) The provider shall remain in change-of-provider status until the base year is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider.

(4) Each factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in change-of-provider status.

(e) Determination of the rate for nursing facility providers reentering the medicaid program.

(1) The per diem rate for each provider reentering the medicaid program shall be determined from either of the following:

(A) A projected cost report if the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more; or

(B) the base-year cost report filed with the agency or the most recent cost report filed preceding the base year, if the provider has actively participated in the program during the most recent 24 months.

(2) If the per diem rate for a provider reentering the program is determined in accordance with paragraph (e)(1)(A), the cost data shall be adjusted to the base-year period.

(3) The provider shall remain under reenrollment status until the base year is reestablished. During this time, the cost data used to determine the initial rates shall be used to determine all subsequent rates for the provider.

(4) Each factor for inflation that is applied to cost data for established providers shall be applied to the cost data for providers in reenrollment status.

(5) If the per diem rate for a provider reentering the program is determined in accordance with paragraph (e)(1)(A), a settlement shall be made in accordance with subsection (f).

(f) Per diem rate errors.

(1) If the per diem rate, whether based upon projected or historical cost data, is audited by the agency and found to contain an error, a direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider with an identified overpayment is no longer enrolled in the medicaid program, the settlement shall be recouped from a facility owned or operated by the same provider or provider corporation, unless other arrangements have been made to reimburse the agency. A net settlement may occur if a provider has more than one facility involved in settlements. In all cases, settlements shall be recouped within 12 months of the implementation of the corrected rates, or interest may be assessed.

(2) The per diem rate for a provider may be increased or decreased as a result of a desk review or audit of the provider's cost reports. Written notice of this per diem rate change and of the audit findings shall be sent to the provider. Retroactive adjustment of the rate paid from a projected cost report shall apply to the same period of time covered by the projected rate.

(3) Each provider shall have 30 days from the date of the audit report cover letter to request an administrative review of an audit adjustment that results in an overpayment or underpayment. The request shall specify the finding or findings that the provider wishes to have reviewed.

(4) An interim settlement, based on a desk review of the historical cost report covering the projected cost report period, may be determined after the provider is notified of the new rate determined from the cost report. The final settlement shall be based on the rate after an audit of the historical cost report.

(5) A new provider that is not allowed to submit a projected cost report for an interim rate shall not be entitled to a retroactive settlement for the first year of operation.

(g) Out-of-state providers.

(1) The rate for out-of-state providers certified to participate in the Kansas medical assistance program shall be the rate approved by the agency.

(2) Each out-of-state provider shall obtain prior authorization by the agency.

(h) Reserve days. Reserve days as specified in K.A.R. 30-10-21 shall be paid at 67 percent of the Kansas medical assistance program per diem rate.

(i) Determination of rate for ventilator-dependent resident.

(1) The request for additional reimbursement for a ventilator-dependent resident shall be submitted to the agency in writing for prior approval. Each request shall include a current care plan for the resident, the most current resident assessment, and an itemized expense list for implementing that care plan.

(2) All of the following conditions shall be met in order for a resident to be considered ventilator-dependent:

(A) The resident is not able to breathe without mechanical ventilation.

(B) The resident uses a ventilator for life support 24 hours a day, seven days a week.

(C) The resident has a tracheostomy or endotracheal tube.

(3) The provider shall be reimbursed at the Kansas medical assistance program daily rate determined for the nursing facility plus an additional amount approved by the agency for the ventilator-dependent resident. The provider shall submit a budget with the detail of the expenditures requested to care for the ventilator-dependent resident. The additional reimbursement shall be negotiated based on the prevailing cost of the individual care plan and subject to an upper payment limit that is based on the comparable rate from the medicare prospective payment system.

(4) No additional amount above that figured at the Kansas medical assistance program daily rate shall be allowed until the service has been authorized by the agency.

(5) The criteria shall be reviewed quarterly to determine if the resident is ventilator-dependent. If a resident is no longer ventilator-dependent, the provider shall not receive additional reimbursement beyond the Kansas medical assistance program daily rate determined for the facility.

(6) The additional reimbursement for the ventilator-dependent resident shall be offset to the cost center of benefit on the nursing facility financial and statistical report. (Authorized by K.S.A. 2007 Supp. 75-7403 and 75-7412; implementing K.S.A. 2007 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008.)

129-10-23a. Nonreimbursable costs. (a) Costs not related to resident care, as set forth in K.A.R. 30-10-1a, shall not be considered in computing reimbursable costs. In addition, the following expenses or costs shall not be allowed:

(1) Fees paid to nonworking directors and the salaries of nonworking officers;

(2) uncollectable debts, which are also known as "bad debts";

(3) donations and contributions;

(4) fund-raising expenses;

(5) taxes, as follows:

(A) Federal income and excess profit taxes, including any interest or penalties paid on these taxes;

(B) state or local income and excess profits taxes;

(C) taxes from which exemptions are available to the provider;

(D) taxes on property that is not used in providing covered services;

(E) taxes levied against any resident and collected and remitted by the provider;

(F) self-employment taxes applicable to individual proprietors, partners, or members of a joint venture; and

(G) interest or penalties paid on federal and state payroll taxes;

(6) insurance premiums on lives of owners and related parties;

(7) the imputed value of services rendered by nonpaid workers and volunteers;

(8) utilization review not related to quality assurance;

(9) costs of social, fraternal, civic, and other organizations that concern themselves with activities unrelated to their members' professional or business activities;

(10) accrued expenses that are not liquidated within 180 days after the end of the cost reporting period;

(11) vending machines and related supplies;

(12) board of director costs;

(13) resident personal purchases;

(14) advertising for resident utilization;

(15) public relations expenses;

(16) penalties, fines, and late charges;

(17) prescription drugs as defined in K.A.R. 30-10-1a;

(18) dental services;

(19) radiology;

(20) lab work;

(21) items or services provided only to non-

Kansas medical assistance program residents and reimbursed from third-party payors;

(22) automobiles and related accessories in excess of $25,000.00 each. Buses and vans for resident transportation shall be reviewed for reasonableness and may exceed $25,000.00 in costs;

(23) provider-owned or related party-owned, -leased, or -chartered airplanes and related expenses;

(24) bank overdraft charges or other penalties;

(25) personal expenses not directly related to the provision of long-term resident care in a nursing facility;

(26) management fees paid to a related organization that are not clearly derived from the actual cost of materials, supplies, or services provided directly to an individual nursing facility;

(27) business expenses not directly related to the care of residents in a long-term care facility. These expenses shall include business investment activities, stockholder and public relations activities, and farm and ranch operations;

(28) legal and other costs associated with litigation, unless the litigation is decided in the provider's favor and is directly related to Kansas nursing facility operations;

(29) lobbying expenses and political contributions.

(b) Purchase discounts, allowances, and refunds shall be deducted from the cost of the items purchased. Refunds of prior years' expenses shall be deducted from the related expenses. (Authorized by K.S.A. 2007 Supp. 75-7403 and 75-7412; implementing K.S.A. 2007 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008.)

129-10-23b. Costs allowed with limitations. (a) The following amortized expenses or costs shall be allowed with limitations:

(1) The provider shall amortize loan acquisition fees and standby fees over the life of the related loan if the loan is related to resident care.

(2) Only the following taxes shall be allowed as amortized costs:

(A) Taxes in connection with financing, refinancing, or refunding operations; and

(B) special assessments on land for capital improvements over the estimated useful life of those improvements.

(3) The start-up cost of a provider with a newly constructed facility or a facility that has been closed for 24 months or more shall be recognized if the cost meets the following criteria:

(A) Is incurred within 90 days of the opening of the facility and related to developing the ability to care for residents;

(B) is amortized over a period of at least 60 months;

(C) is consistent with the facility's federal income tax return and internal and external financial reports, with the exception of paragraph (a)(3)(B); and

(D) is identified in the cost report as a start-up expense, which may include the following:

(i) Administrative and nursing salaries;

(ii) utilities;

(iii) taxes, as identified in paragraphs (a)(2)(A) and (B);

(iv) insurance;

(v) mortgage interest;

(vi) employee training costs; and

(vii) any other allowable costs incidental to the operation of the facility.

(4) Each cost that can properly be identified as an organization expense or can be capitalized as a construction expense shall be appropriately classified and excluded from the start-up cost.

(5) Organization and other corporate costs, as defined in K.A.R. 30-10-1a, of a provider that is newly organized shall be amortized over a period of at least 60 months beginning with the date of organization.

(A) The costs shall be reasonable and limited to the preparation and filing of documents required by the various governmental entities, the costs of preparing sale or lease contracts, and the associated legal and professional fees.

(B) The costs shall not include expenses of resolving contested issues of title or disputes arising from the performance of contracts or agreements related to the purchase or sale of a property or business.

(b) Membership dues and costs incurred as a result of membership in professional, technical, or business-related organizations shall be allowable. However, similar expenses specified in paragraph (a)(9) of K.A.R. 129-10-23a shall not be allowable.

(c) Each provider shall include the costs associated with services, facilities, equipment, and supplies furnished to the nursing facility by related parties, as defined in K.A.R. 30-10-1a, in the allowable cost of the facility at the actual cost to the related party, except that the allowable cost to the nursing facility provider shall not exceed the lower of the actual cost or the market price.

(d) If a provider pays an amount in excess of

the market price for equipment, supplies, or services, the agency shall use the market price to determine the allowable cost under the Kansas medical assistance program in the absence of a clear justification for the premium.

(e) The net cost of job-related training and educational activities shall be an allowable cost. The allowable cost shall include the net cost of orientation and on-the-job training.

(f) Resident-related transportation costs shall include only reasonable costs that are directly related to resident care. Transportation costs not directly related to resident care shall not be allowable. Estimates shall not be acceptable.

(g)(1) Lease payments shall be reported in accordance with the financial accounting statements of the financial accounting standards board.

(2) Sale-leaseback transactions shall have the costs limited to the amount that the provider would have included in reimbursable costs if the provider had retained legal title to the facilities and equipment. These costs shall include mortgage interest, taxes, depreciation, insurance, and maintenance costs. The lease cost shall not be allowable if it exceeds the ownership costs before the sale-leaseback transaction.

(h) If the expenses reported for the current period are not paid within one year after the invoice date, the expenses shall be disallowed. (Authorized by K.S.A. 2007 Supp. 75-7403 and 75-7412; implementing K.S.A. 2007 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008.)

129-10-25. Real and personal property fee. (a) A real and personal property fee shall be developed by the agency in lieu of an allowable cost for ownership or lease expense, or both. The fee shall be facility-specific and shall not change as a result of change of ownership, a change in lease, or reenrollment in the medicaid program by providers. An inflation factor may be applied to the fee on an annual basis.

The real and personal property fee shall include an appropriate component for the following:

(1) Rent or lease expense;

(2) interest expense on a real estate mortgage;

(3) amortization of leasehold improvements; and

(4) depreciation on buildings and equipment.

(b)(1) The real and personal property fee shall be determined based on one of the following methodologies:

(A) For providers enrolled in the Kansas medical assistance program with a real and personal property fee for each facility, the real and personal property fee shall be the sum of the property allowance and value factor.

(B) For providers reenrolling in the Kansas medical assistance program or providers enrolling for the first time but operating in a facility that was previously enrolled in the program, the real and personal property fee shall be the sum of the last effective property allowance and the last effective value factor for the facility.

(C) The real and personal property fee for a newly constructed nursing facility or a nursing facility that enters the Kansas medical assistance program and has not had a fee established previously shall be calculated based on the following methodology:

(i) A projected real and personal property fee shall be calculated using a projected cost report by dividing the total of the four real and personal property fee components reported in the ownership cost center by the greater of the total number of resident days reported or 85 percent of the licensed capacity for the cost report period.

(ii) A historical real and personal property per diem shall be calculated using a historical cost report by dividing the total of the four line items reported in the ownership cost center by the greater of the total number of resident days reported or 85 percent of the licensed capacity for the cost report period.

(iii) A settlement between the projected and historical rates, which shall include the real and personal property fee, shall be made in accordance with K.A.R. 129-10-18 (e).

(2) The real and personal property fee shall be subject to an upper payment limit. The upper payment limit for the real and personal property fee shall be determined by the median real and personal property fee plus a percentage of the median. The percentage factor applied shall be determined by the secretary.

(c)(1) The depreciation and amortization component of the real and personal property fee shall meet these criteria:

(A) Be identifiable and recorded in the provider's accounting records;

(B) be based on the historical cost of the asset as established in this regulation; and

(C) be prorated over the estimated useful life of the asset using the straight-line method.

(2)(A) Appropriate recording of depreciation shall include the following:

(i) Identification of the depreciable assets in use;

(ii) the assets' historical costs;

(iii) the method of depreciation;

(iv) the assets' estimated useful life; and

(v) the assets' accumulated depreciation.

(B) Each provider shall report gains and losses on the sale of depreciable personal property on the cost report at the time of the sale. The provider shall record trading of depreciable property in accordance with the income tax method of accounting for the basis of property acquired. Under the income tax method, gains and losses arising from the trading of assets shall not be recognized in the year of trade but shall be used to adjust the basis of the newly acquired property.

(3) The cost basis shall not include costs attributable to the negotiation or final purchase of the facility, which may include legal fees, accounting fees, travel costs, and the cost of feasibility studies.

(d) Any provider may request that the agency rebase the real and personal property fee. Providers shall submit rebase requests for completed capital improvement projects or phases of capital improvements projects. The following methodology shall be used to determine a revised real and personal property fee based on the rebase request.

(1) Rebase requests shall be reviewed to determine a revised real and personal property fee if the provider meets the following capital expenditure thresholds:

(A) $25,000.00 for facilities with 50 or fewer beds; or

(B) $50,000.00 for facilities with 51 or more beds.

(2) The per diem based on the interest expense, depreciation expense, and amortization of leasehold improvements shall be added to the real and personal property fee in effect on the date that the rebase is made effective. Interest expense reported in the operating cost center shall not be included in the request for a rebase of the real and personal property fee. Interest on loans for real and personal property that is included in a rebase shall be reported with mortgage interest in the ownership cost center.

(3) The number of resident days used in the denominator of the real and personal property fee calculation shall be based on the total number of resident days from the most recent desk-reviewed cost report to rebase the property fee. The resident days shall be subject to the 85 percent minimum occupancy requirement, including any new beds documented in the request for a rebase.

(4) The revised real and personal property fee shall be subject to the upper payment limit in effect on the date the rebase is made effective.

(5)(A) If the number of beds of an existing nursing facility is increased by the construction of a new addition to the existing facility, the real and personal property fee established through the rebase shall be effective according to either of the following schedules:

(i) On the first day of the month in which the new beds were certified if the certification date was on or before the 15th of the month; or

(ii) on the first day of the month following the month in which the beds were certified if the certification date is on or after the 16th of the month.

(B) If the capital expenditure that is the basis for the rebase request is not related to an increased number of beds, the real and personal property fee established through the rebase shall be effective according to either of the following schedules:

(i) On the first day of the month in which the complete documentation is received, if the request is received on or before the 15th of the month; or

(ii) on the first day of the month following the month in which the complete documentation is received, if the request is received on or after the 16th of the month.

(C) Complete documentation shall include the following:

(i) The depreciation or amortization schedule reflecting the expense, including the construction-in-progress subsidiary ledger;

(ii) the loan agreement;

(iii) the amortization schedule for interest;

(iv) invoices;

(v) receipts for contractor fees; and

(vi) receipts for other costs associated with the capital expenditure.

(6) Invoices or contractor statements dated more than two years before the date the rebase request is received shall not be allowed. (Authorized by K.S.A. 2007 Supp. 75-7403 and 75-7412; implementing K.S.A. 2007 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008.)

129-10-26. Interest expense. (a) Only necessary interest on working capital or personal property loans shall be an allowable expense. Interest on real estate or personal property covered

by the real and personal property fee in accordance with K.A.R. 129-10-25 shall not be included.

(b) The interest expense shall be incurred on indebtedness established with either of the following:

(1) Lenders or lending organizations not related to the borrower; or

(2) partners, stockholders, home office organizations, or related parties, if the following requirements are met:

(A) The terms and conditions of payment of the loans shall resemble terms and conditions of an arm's-length transaction by a prudent borrower with a recognized, local lending institution with the capability of entering into a transaction of the required magnitude. Allowable interest expense shall be limited to the annual expense submitted on the loan amortization schedule, unless the loan principal is retired before the end of the amortization period, or working capital loans if the period is one year or less; and

(B) the provider shall demonstrate, to the satisfaction of the agency, a primary business purpose for the loan other than increasing the per diem rate.

(C) The transaction shall be recognized and reported by all parties for federal income tax purposes.

(c) If the general fund of a nursing facility borrows from a donor-restricted fund, this interest expense shall be an allowable cost. In addition, if a nursing facility operated by members of a religious order borrows from the order, interest paid to the order shall be an allowable cost.

(d) The interest expense shall be reduced by the investment income from restricted or unrestricted idle funds or funded reserve accounts, unless that income is from gifts and grants, whether restricted or unrestricted, that are held in a separate account and not commingled with other funds. Income from the provider's qualified pension fund shall not be used to reduce interest expense.

(e) Interest earned on restricted or unrestricted reserve accounts of industrial revenue bonds or sinking fund accounts shall be offset against interest expense and limited to the interest expense on the related debt.

(f) Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost or the cost basis recognized for program purposes shall not be considered to be reasonably related to resident care. (Authorized by K.S.A. 2007 Supp. 75-7403 and 75-7412; implementing K.S.A. 2007 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008.)

129-10-27. Central office costs. (a) Allocation of costs. Allocation of central office costs shall be reasonable, conform to general accounting rules, and allowed only to the extent that the central office is providing a service normally available in the nursing facility. Central office costs shall not be recognized or allowed to the extent that they are unreasonably in excess of the central office costs of similar nursing facilities in the program. The burden of furnishing sufficient evidence to establish a reasonable level of costs shall be on the provider. All expenses reported as central office costs shall be limited to the actual resident-related costs of the central office.

(1) The provider shall report cost of ownership or the arm's-length lease expense, utilities, maintenance, property taxes, insurance, and other plant operating costs of the central or regional office space for resident-related activities report as central office costs.

(2) The provider shall report all administrative expenses incurred by central and regional offices as central office costs. These may include the following:

(A) Salaries;

(B) benefits;

(C) office supplies;

(D) printing, management, and consultant fees;

(E) telephones and other forms of communications;

(F) travel and vehicle expenses;

(G) allowable advertising;

(H) licenses and dues; and

(I) legal, accounting, data processing, insurance, and interest expenses.

The administrative expenses reported as central office costs shall not be directed to individual facilities operated by the provider or reported on any other line of the cost report.

(3) Nonreimbursable costs in K.A.R. 129-10-23a, costs allowed with limitations in K.A.R. 129-10-23b, and the revenue offsets in K.A.R. 30-10-23c shall apply to central office costs.

(4) Estimates of central office costs shall not be allowable.

(b) Central office salary and other limitations.

(1) Salaries of employees performing the duties for which they are professionally qualified shall be allocated to the direct health care cost center or

the indirect health care cost center as appropriate for the duties performed. Professionally qualified employees shall include licensed and registered nurses, dietitians, and others that may be designated by the agency.

(2) Salaries of chief executives, corporate officers, department heads, and other employees with ownership interests of five percent or more shall be deemed owner's compensation, and the provider shall report these salaries as owner's compensation in the operating cost center.

(3) The provider shall include the salary of an owner or related party performing a resident-related service for which the person is professionally qualified in the appropriate cost center for that service, subject to the salary limitations for the owner or related party.

(4) The provider shall report salaries of all other central office personnel performing resident-related administrative functions in the operating cost center.

(5) Each provider operating a central office shall complete and submit detailed schedules of all salaries and expenses incurred in each fiscal year. Failure to submit detailed central office expenses and allocation methods shall result in an incomplete cost report. The provider shall submit methods for allocating costs to all facilities in this and any other states.

(6) A central office cost limit may be established by the agency within the overall operating cost center upper payment limit.

(7) The provider may allocate and report bulk purchases by the central office staff in the appropriate cost center of each facility if sufficiently documented. Questionable allocations shall be transferred to the central office cost line within the operating cost center. (Authorized by K.S.A. 2007 Supp. 75-7403 and 75-7412; implementing K.S.A. 2007 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008.)

129-10-200. Definitions for intermediate care facility for mentally retarded (ICF-MR). (a) "Accrual basis of accounting" means that the revenue of the provider is reported in the period when the revenue is earned, regardless of when it is collected, and expenses are reported in the period in which the expenses are incurred, regardless of when the expenses are paid.

(b) "Adequate cost and other accounting information" means that the data, including source documentation, is accurate, current, and in sufficient detail to accomplish the purposes for which the data is intended. Source documentation, including petty cash payout memoranda and original payout invoices, shall be valid only if the documentation originated at the time and near the place of the transaction. In order to provide the required costs data, financial and statistical records shall be maintained in a manner that is consistent from one period to another. This requirement shall not preclude a beneficial change in accounting procedures if there is a compelling reason to effect a change of procedures.

(c) "Agency" means the Kansas department of social and rehabilitation services.

(d) "Ancillary services and other medically necessary services" mean those special services or supplies for which charges are made in addition to those for routine services.

(e) "Approved staff educational activities" means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of client care in an ICF-MR. These activities shall be licensed when required by state law.

(f) A "client day" means that period of service rendered to a client between the census-taking hours on two successive days and all other days for which the provider receives payment, either full or partial, for any Kansas medical assistance program or non-Kansas medical assistance program client who was not in the home. The census-taking hours consist of 24 hours beginning at midnight.

(g) "Common ownership" means that any individual or an organization holds five percent or more ownership or equity of the ICF-MR and of the facility or organization serving the ICF-MR.

(h) "Control" means that an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

(i) "Cost finding" means the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered.

(j) "Costs related to client care" means all necessary and proper costs, arising from arm's-length transactions in accordance with general accounting rules, that are appropriate and helpful in developing and maintaining the operation of client care facilities and activities. Specific items of expense shall be limited pursuant to K.A.R. 30-10-218, K.A.R. 30-10-219, K.A.R. 30-10-220, K.A.R.

30-10-221, K.A.R. 30-10-222, K.A.R. 30-10-223, K.A.R. 30-10-224, and K.A.R. 30-10-225.

(k) "Costs not related to client care" means costs that are not appropriate or not necessary and proper in developing and maintaining the ICF-MR operation and activities. These costs shall not be allowable in computing reimbursable costs.

(l) "Extra care" means temporary care required by a client that takes more time, services, and supplies than the care provided an average ICF-MR client. Extra care shall require prior authorization before reimbursement.

(m) "General accounting rules" mean the generally accepted accounting principles as established by the American institute of certified public accountants except as otherwise specifically indicated by ICF-MR program policies and regulations. Adoption of any of these principles shall not supersede any specific regulations and policies of the ICF-MR program.

(n) "Inadequate care" means any act or failure to take action that potentially could be physically or emotionally harmful to a recipient.

(o) "Inspection of care review of intermediate care facilities for the mentally retarded" means a yearly, client-oriented review of only Kansas medical assistance program clients, conducted by a team from the Kansas department on aging consisting of a nurse, a social worker, and a medical doctor, to determine whether those clients' needs are being met.

(p) "Intermediate care facility for the mentally retarded" and "ICF-MR" mean a facility that has met state licensure standards and meets the following conditions:

(1) Is primarily for the diagnosis, treatment, or habilitation of the mentally retarded or persons with related conditions; and

(2) provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or habilitative services to help each individual function at that person's greatest ability.

(q) "Levels-of-care model" means a residential model with five residential facility levels established by service-intensity categories and size of facilities, according to the following:

(1) Small facility: four through eight beds;

(2) medium facility: nine through 16 beds; and

(3) large facility: more than 16 beds.

(r) "Mental retardation" means subaverage general intellectual functioning that originates in the developmental period and is associated with impairment in adaptive behavior, as defined by the 1983 revision of "classification in mental retardation," authored by the American association of mental deficiency.

(s) "Net cost of educational activities" means the cost of approved educational activities less any grants, specific donations, or reimbursements of tuition.

(t) "Nonworking owners" means any individual or organization who has an interest of at least five percent in the provider and does not perform a client-related function for the ICF-MR.

(u) "Nonworking related party" means any related party, as defined in this regulation, who does not perform a client-related function for the ICF-MR.

(v) "Organization costs" mean those costs directly incidental to the creation of the corporation or other form of business. These costs are intangible assets in that they represent expenditures for rights and privileges that have value to the enterprise. The services inherent in organization costs extend over more than one accounting period and shall be amortized over a period of not less than 60 months from the date of incorporation.

(w) "Owner-related party compensation" means salaries, drawings, consulting fees, or other payments paid to or on behalf of any owner with an interest of at least five percent in the provider or any related party, as defined in this regulation, whether the payment is from a sole proprietorship, partnership, corporation, or nonprofit organization.

(x) "Persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

(1) Is attributable to either of the following:

(A) Cerebral palsy or epilepsy; or

(B) any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons and requires treatment or services similar to those required for these persons;

(2) is manifested before the person attains the age of 22;

(3) is likely to continue indefinitely; and

(4) results in substantial functional limitations in three or more of the following areas of major life activity:

(A) Self-care;

(B) understanding and use of language;

(C) learning;
(D) mobility;
(E) self-direction; and
(F) capacity for independent living.

(y) "Physician extender" means a person who is registered as a physician's assistant or licensed advanced registered nurse practitioner in the jurisdiction where the service is provided and who is working under supervision as required by law or state regulation.

(z) "Plan of care" means a document that states the need for care, the estimated length of the program, the methodology to be used, and the expected results.

(aa) "Projected cost report" means a cost report submitted to the agency by a provider prospectively for a 12-month period. The projected cost report is based on an estimate of the costs, revenues, resident days, and other financial data for the 12-month period.

(bb) "Projection status" means that a provider has been assigned a previous provider's rate for a set period or is allowed to submit a projected cost report. The provider shall submit a historic cost report at the end of the projection period to be used for a settlement of the interim rates and to determine a prospective rate.

(cc) "Provider" means the operator of the ICF-MR specified in the provider agreement.

(dd) "Psychological evaluations or reevaluations in intermediate care facilities for the mentally retarded" means a review of the previous pertinent psychological material to determine if the evaluation is consistent with the client's present status.

(ee) "Related parties" means two or more parties with a relationship in which one party has the ability to influence another party to the transaction such that one or more of the transacting parties might fail to pursue its own separate interests fully. This term shall include parties related by family, business, or financial association or by common ownership or control. Transactions between related parties shall not be considered to have arisen through arm's-length negotiations. Transactions or agreements that are illusory or a sham shall not be recognized.

(ff) "Related to the ICF-MR" means that the facility, to a significant extent, is associated or affiliated with, has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

(gg) "Representative" means legal guardian, conservator, or representative payee as designated by the social security administration, or any person who is designated in writing by the client to manage the client's personal funds and is willing to accept the designation.

(hh) "Routine services and supplies" mean services and supplies that are commonly stocked for use by or provided to any client. These services and supplies shall be included in the provider's cost report.

(1) Routine services and supplies may include the following:

(A) All general nursing services;

(B) items that are furnished routinely to all clients;

(C) items stocked at nursing stations in large quantities and either distributed or utilized individually in small quantities;

(D) routine items covered by the pharmacy program if ordered by a physician for occasional use; and

(E) items that are used by individual clients but are reusable and expected to be available in a facility.

(2) Routine services and supplies shall be distinguished from nonroutine services and supplies that are ordered or prescribed by a physician on an individual or scheduled basis. Medication ordered may be considered nonroutine if either of the following conditions is met:

(A) The medication is not a stock item of the facility.

(B) The medication is a stock item with unusually high usage by the individual for whom prior authorization may be required.

(3) Routine services and supplies shall not include ancillary services and other medically necessary services as defined in subsection (d) and also shall not include those services and supplies the client must provide.

(4) Reasonable transportation expenses necessary to secure routine and nonemergency medical services shall be considered reimbursable through the medicaid per diem rate.

(ii) "Working trial balance" means the summary from the provider's general ledger that was used in completing the cost report. This summary shall contain the account number, a description of the account, the amount of the account, and the line of the cost report specifying the account. (Authorized by K.S.A. 2007 Supp. 75-7403 and 75-7412; implementing K.S.A. 2007 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008.)

129-10-210. ICF-MR reimbursement. (a) (1) Each provider with a current signed provider agreement shall be paid a per diem rate for services furnished to eligible Kansas medical assistance program clients. Payment shall be for the type of medical or health care required by the beneficiary as determined by either of the following:

(A) The attending physician's or physician extender's certification upon admission; or

(B) inspection of care and utilization review teams, as specified in K.A.R. 30-10-207.

(2) Payment for services shall not exceed the type of care the provider is certified to provide under the Kansas medical assistance program. The type of care required by the beneficiary may be verified by the agency before and after payment. No payment shall be made for care or services determined to be the result of unnecessary utilization.

(A) Initial eligibility for ICF-MR level services shall be determined based on a screening completed by the agency or its designee.

(B) Continued eligibility for ICF-MR level services shall be determined by a professional review of the client by the utilization review team of the Kansas department on aging.

(b) Payment for routine services and supplies, pursuant to K.A.R. 129-10-200, shall be included in the per diem reimbursement. No provider shall bill or be reimbursed for these services and supplies.

(1) The following durable medical equipment, medical supplies, and other items and services shall be considered routine:

(A) Alternating pressure pads and pumps;

(B) armboards;

(C) bedpans, urinals, and basins;

(D) bed rails, beds, mattresses, and mattress covers;

(E) canes;

(F) commodes;

(G) crutches;

(H) denture cups;

(I) dressing items, including applicators, tongue blades, tape, gauze, bandages, adhesive bandages, pads and compresses, elasticized bandages, petroleum jelly gauze, cotton balls, slings, triangle bandages, and pressure pads;

(J) emesis basins and bath basins;

(K) enemas and enema equipment;

(L) facial tissues and toilet paper;

(M) footboards;

(N) foot cradles;

(O) gel pads or cushions;

(P) geriatric chairs;

(Q) gloves, rubber or plastic;

(R) heating pads;

(S) heat lamps and examination lights;

(T) humidifiers;

(U) ice bags and hot water bottles;

(V) intermittent positive-pressure breathing (IPPB) machines;

(W) IV stands and clamps;

(X) laundry, including personal laundry;

(Y) lifts;

(Z) nebulizers;

(AA) occupational therapy that exceeds the quantity of services covered by the Kansas medical assistance program;

(BB) oxygen masks, stands, tubing, regulators, hoses, catheters, cannulae, and humidifiers;

(CC) parenteral and enteral infusion pumps;

(DD) patient gowns and bed linens;

(EE) physical therapy that exceeds the quantity of services covered by the Kansas medical assistance program;

(FF) restraints;

(GG) sheepskins and foam pads;

(HH) speech therapy that exceeds the quantity of services covered by the Kansas medical assistance program;

(II) sphygmomanometers, stethoscopes, and other examination equipment;

(JJ) stretchers;

(KK) suction pumps and tubing;

(LL) syringes and needles;

(MM) thermometers;

(NN) traction apparatus and equipment;

(OO) underpads and adult diapers, disposable and nondisposable;

(PP) walkers;

(QQ) water pitchers, glasses, and straws;

(RR) weighing scales;

(SS) wheelchairs;

(TT) irrigation solution, including water and normal saline;

(UU) lotions, creams, and powders, including baby lotion, oil and powders;

(VV) first aid-type ointments;

(WW) skin antiseptics, including alcohol;

(XX) antacids;

(YY) mouthwash;

(ZZ) over-the-counter analgesics;

(AAA) two types of laxatives;

(BBB) two types of stool softeners;

(CCC) nutritional supplements;
(DDD) blood glucose monitors and supplies;
(EEE) urinary supplies; and
(FFF) nutritional therapy.

(c) Payment for ancillary services, as defined in K.A.R. 129-10-200, shall be billed separately when the services are required.

(d) Payment for a day service program for clients of an ICF-MR shall be included in the per diem reimbursement. Each provider shall allow the client or the client's guardian to select a day service program offered by another agency. The other agency shall be licensed and unencumbered by documented service deficiencies that would prevent the provider from becoming certified or remaining certified as a medicaid provider. The provider shall pay the actual cost of the service provided by the other agency, which shall not exceed 24 percent of the provider's approved per diem rate. Expenses incurred by the provider for this service shall be allowable expenses and may be reported on the provider's financial and statistical report.

(e) Payment shall be limited to providers who accept, as payment in full, the amount paid in accordance with the fee structure established by the Kansas medical assistance program. (Authorized by K.S.A. 2007 Supp. 75-7403 and 75-7412; implementing K.S.A. 2007 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008.)

Article 14.—CHILDREN'S HEALTH INSURANCE PROGRAM

129-14-22. Rights of applicants and recipients. (a) Right to information. Each applicant or recipient shall be provided with information concerning the program. Upon request, each applicant or recipient shall be furnished with information by the agency, and the eligibility criteria and coverage available shall be explained to each applicant or recipient.

(b) Right to submit an application. Each applicant shall have the right to submit an application regardless of any question of eligibility or agency responsibility. The right of any individual to submit an application shall not be abridged.

(c) Right to a determination of eligibility for coverage. Each applicant or recipient shall be given an opportunity to present any request and to explain the applicant's or recipient's situation.

(d) Right to withdraw from program. Each applicant shall have the right to withdraw the application at any time between the date the application is signed and the date the notice of the agency's decision is mailed. Any recipient may withdraw from the program at any time.

(e) Right to a prompt decision. Each applicant shall have the right to have a decision rendered on an application within 15 calendar days of the agency's receipt of a signed application and all supporting documentation, but no later than 45 days from the date the signed application is received. Each recipient shall have the right to have a decision rendered on any formal request within 30 days of its receipt by the agency.

(f) Right to the correct amount of coverage. Each individual, if eligible, shall be entitled to the correct amount of coverage, based upon the program regulations.

(g) Right to written notification of action. Each individual shall have the right to a written notification of agency action concerning eligibility for the healthwave program. For children eligible for presumptive coverage as specified in K.A.R. 129-14-51, the notice shall be sent from the qualified entity as required in K.A.R. 129-14-52.

(h) Right to equal treatment. Each individual shall have the right to be treated in the same manner as that for other individuals who are in similar circumstances.

(i) Right to a fair hearing. Except for children for whom a determination under presumptive medical assistance as specified in K.A.R. 129-14-51 has been made, each individual shall have the right to request a fair hearing if the individual is dissatisfied with any agency decision or lack of action in regard to the application for or receipt of coverage. (Authorized by K.S.A. 2005 Supp. 75-7412; implementing K.S.A. 2005 Supp. 75-7412 and 75-7413, as amended by L. 2006, ch. 4, § 2; effective Aug. 11, 2006.)

129-14-27. Financial eligibility. (a) Persons whose needs are to be considered in determining each child's eligibility.

(1) If the child lives with a parent or parents, the needs of all individuals in the filing unit in accordance with K.A.R. 30-14-2 shall be considered.

(2) If the child does not live with a parent and is under age 18, only the needs of the child and any siblings of the child who are in the family group shall be considered.

(3) If the child is age 18 and does not reside

with a parent, only the needs of the child shall be considered.

(b) Poverty level determination. Total monthly income, as described above, shall not exceed a percentage of the official federal poverty income guidelines, as established in K.A.R. 30-6-103, to be determined by the agency to be eligible for coverage. If the agency determines that the program funds appropriated are insufficient to fund up to this income level, a lower income level shall be implemented by the agency, and the changes shall be published by the agency in the Kansas register.

(c) Continuous eligibility. Except for children determined eligible for presumptive medical assistance as specified in K.A.R. 129-14-52, each child who becomes eligible for coverage under this regulation shall continue to be eligible for 12 months beginning with the month in which the child is enrolled or reenrolled for coverage in the healthwave program, without regard to any changes in family income. The general eligibility requirements of K.A.R. 30-14-26 shall continue to be met. (Authorized by and implementing K.S.A. 2005 Supp. 75-7412; effective June 30, 2006.)

129-14-51. Presumptive eligibility for healthwave. (a) Each child, as defined in K.A.R. 30-14-2(a)(2), shall be eligible for a presumptive period if a qualified entity, as specified in K.A.R. 129-14-52, designated by the agency determines that the child meets the presumptive eligibility requirements.

(b) Each eligible child shall meet the financial requirements of K.A.R. 129-14-27(b), K.A.R. 129-14-27(a), and K.A.R. 30-14-29. Each eligible child shall be uninsured as specified in K.A.R. 30-14-26(a) and (b). Each eligible child shall also meet the general eligibility requirements of K.A.R. 30-14-25 (a), (b), and (e).

(c) The presumptive period shall begin on the date the qualified entity makes an eligibility determination. The presumptive period shall end on the last day of the month following the month in which the determination is made, unless an application for medical assistance is received. If an application is filed in accordance with K.A.R. 30-14-20 before this date, the presumptive period shall end on the last day of the month in which a full determination is made according to this article.

(d) Each child shall be eligible for only one period of presumptive eligibility within a 12-month period under this article or under K.A.R. 129-6-151. The 12-month period shall begin on the first day of presumptive eligibility. (Authorized by and implementing K.S.A. 2005 Supp. 75-7412; effective June 30, 2006.)

129-14-52. Healthwave presumptive eligibility to be determined by qualified entities. (a) Each qualified entity shall be designated by the agency to make determinations of presumptive eligibility as specified in K.A.R. 129-14-51.

(b) Each qualified entity shall be authorized to provide health care items and services and to receive reimbursement for these items and services under the medical assistance program.

(c) For each determination of presumptive eligibility, a qualified entity shall perform the following:

(1) Make a finding of presumptive eligibility pursuant to K.A.R. 129-14-51(b) or 129-6-151(b);

(2) notify the child's parent or caretaker, in writing, of the results of the determination at the time of the determination;

(3) provide the parent or caretaker with an application for regular medical assistance. For children determined to be presumptively eligible, the qualified entity shall notify the child's parents or caretaker that, unless a regular medical assistance application is submitted before the last day of the month following the month of the presumptive determination, eligibility shall end on that date;

(4) assist the child's parent or caretaker in completing and filing a regular medical assistance application; and

(5) notify the agency of the presumptive determination within five working days after the determination. (Authorized by and implementing K.S.A. 2005 Supp. 75-7412; effective June 30, 2006.)